Worker's Compensation Board of Indiana
*Preliminary Guidelines for Determining the Pecuniary Liability of an Employer to a Medical Service Facility

In order to carry out the intent of the Worker's Compensation Act and effectuate Indiana Code 22-3-3-5.2(b)(2), the Board hereby adopts the following guidelines:

Physical Therapy- Medicare caps on the number of approved visits per year shall not apply to physical therapy performed in a hospital setting.

ASC and Outpatient Procedures- Ambulatory Outpatient Surgical Centers, as defined at IC 16-18-2-14, are considered Medical Service Facilities under IC 22-3-6-1(j) and shall be paid as such pursuant to IC 22-3-3-5.2(b).

Facilities shall be reimbursed for reasonable and necessary procedures conducted there in contradiction of CMS approved facility lists[1], as agreed upon between the injured worker, the employer and the medical provider. This alternative facility setting agreement must be in writing, in clearly stated terms, and include a description of the services to be performed and any other specific details and arrangements along with dated signatures of all parties. Services and procedures thus rendered are payable according to a pre-negotiated fee arrangement between the facility and the employer, or a relevant pre-existing contract. The fee agreement and alternative facility setting agreement must be memorialized in writing prior to performing the medical service or procedure.

This provision is in furtherance of the CMS practice of using the least restrictive setting for the procedure to be performed.

Medicare Reductions- The 2% sequester reductions applied by CMS shall not be included in bill calculation under IC 22-3-3-5.2.

Repackaged Drugs- Medical service providers billing for repackaged legend drugs under IC 22-3-3-4.5 must include both the repackaged NDC and the original manufacturer's NDC, in that order, on the bill.

Excluded Services – Reasonable and necessary services or products, as defined in IC 22-3-6-1(l), that are excluded under Medicare regulations, as listed in the *Medicare National Coverage Determinations Manual*, should be reimbursed in accordance with IC 22-3-6-1(k)(1), in the same community (as defined in IC 22-3-6-1(h)) for a like service or product to injured persons, if not covered by a relevant contract or payment agreement.

***Subject to change prior to June 30, 2014**

[1] See 78 FR 43622 Addendum E and https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html